Nos. 89-1391, 1392



IN THE

# Supreme Court of the United States

OCTOBER TERM, 1990

DR. IRVING RUST, ET AL.,

*Petitioners,*

—v.—

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

*Respondent.*

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THE STATE OF NEW YORK, ET AL.,

*Petitioners,*

—v.—

DR. LOUIS SULLIVAN, or his successor, Secretary of the United States Department of Health and Human Services,

*Respondent.*

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ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

## BRIEF OF *AMICI CURIAE* PLANNED PARENTHOOD FEDERATION OF AMERICA AND THE NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION IN SUPPORT OF PETITIONERS

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## STATEMENT OF INTEREST OF AMICI[1]

*Planned Parenthood Federation of America* (PPFA) is a not-for-profit New York corporation. It is the leading national voluntary public health organization in the field of family planning. PPFA has 172 affiliates which operate 879 clinics in 48 states. Planned Parenthood clinics offer a broad range of family planning methods and related medical and educational services. Fifty-four affiliates offer abortion services. All affiliates are required by PPFA medical standards to offer counseling to pregnant women on all options for handling the pregnancy, including carrying to term, adoption and abortion. Affiliates must provide referral to whatever service the patient requests.

One hundred and thirty-five Planned Parenthood affiliates receive grants under Title X of the Public Health Service Act, amounting to approximately $34,000,000 in federal funds. On February 2, 1988, PPFA filed suit on behalf of those affiliates[2] in the federal district court for the district of Colorado, seeking a nationwide injunction against enforcement of the regulations at issue in this case. On February 15, 1988, ruling from the bench, the court granted the requested relief, enjoining the defendant from enforcing the regulations against any Planned Parenthood affiliate.[3] *Planned Parenthood Federation of America v. Bowen*, 680 F. Supp. 1485 (D. Colo. 1988) (preliminary injunction order incorporating bench ruling *nunc pro tunc*). On June 15, 1988, the court issued a permanent injunction. 687 F. Supp. 540 (D. Colo. 1988). Defendant appealed to the United States Court of

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1 The parties have consented to the filing of this brief in letters on file with the Court.

2 Other named plaintiffs in the case included the two Planned Parenthood affiliates in Utah and Colorado, Boulder Valley Women's Clinic, and three physicians. The lawsuit specifically excluded any affiliate which was at that time a plaintiff in any other case challenging the regulations. The Planned Parenthood affiliates which are plaintiffs in the instant case are not, therefore, the subject of the Colorado case.

3 The injunction did not extend to the Planned Parenthood affiliates which are the plaintiffs in this case. *See supra* note 2.

Appeals for the Tenth Circuit; argument was heard on May 11, 1989; and a decision is pending.

PPFA's interest in this case is direct and immediate. The outcome of this case may well determine whether Planned Parenthood affiliates will be forced to choose between the loss of millions of dollars in federal funds and compliance with requirements which are directly at odds with their organizational standards, standards of good medical care and medical ethics.

*National Family Planning and Reproductive Health Association* (NFPRHA) is a nonprofit membership corporation designed to improve and expand the delivery of comprehensive family planning and reproductive health care information and services throughout the United States. NFPRHA's membership, which includes family planning clinics, community health centers, state and local health departments and PPFA affiliates, comprise 85 percent of the agencies and organizations that operate family planning programs with funds received under Title X.

On February 2, 1988, NFPRHA filed suit on behalf of its membership in the federal district court for the district of Massachusetts, challenging the regulations at issue in this case.[4] That court issued a nationwide injunction on March 3, 1988. *Commonwealth of Massachusetts v. Bowen*, 679 F. Supp. 137 (D. Mass. 1988). On appeal, the Court of Appeals for the First Circuit, sitting *en banc*, affirmed. 899 F.2d 53 (1st Cir. 1990). The government petitioned this Court for certiorari and decision on that petition is pending. No. 89-1929.

Like PPFA, NFPHRA's interest in this case is direct and immediate. The outcome of this case may well determine the rights of its members to continue to provide medically sound and ethical health care while receiving millions of dollars in federal grants.

*Amici* have a unique contribution to make to this case. This brief calls upon the vast experience of their membership (collectively representing 90% of the 3,900 Title X-funded clinics) in administering family planning programs as well as

4 Plaintiffs in that suit include the Commonwealth of Massachusetts, several local reproductive health organizations and physicians. Excluded from the suit are members suing elsewhere, such as affiliates of PPFA.



the voluminous records developed in their lawsuits challenging the new Title X regulations. This experience will show the profoundly destructive impact which the new regulations would have on the health and critical life choices of the millions of women the federal program was designed to serve.

## SUMMARY OF ARGUMENT

The new regulations violate the first amendment because they have a significant coercive effect on the exercise of the right to receive information. Unlike other conditions on the receipt of government funds this Court has dealt with in the past, the new regulations affirmatively harm the intended beneficiaries of governmental assistance. The regulations' blend of censorship and coerced speech leave a woman worse off for having accepted the government's offer of aid than she would be if the government had never created a family planning program. By offering medical care and then, without warning, withholding information that is an integral and expected part of that care, the government has effectively suppressed the receipt of information necessary to make critical life decisions.

The regulations similarly violate the right to privacy. By interfering with the flow of information between health provider and patient, the regulations erect an affirmative obstacle to a woman's exercise of the right to choose between abortion and childbirth.

The regulations are not rationally related to any legitimate state interest. If that constitutional test has any meaning, it must be that government may not achieve even its legitimate ends by the suppression of information. To do so undermines our status as a free people.

The regulations also violate the Title X statute. First, they redefine the funds subject to the statute's abortion prohibition in a manner that contradicts the plain meaning of the statute. Second, by prohibiting medically appropriate referrals and instituting onerous separation requirements between

the Title X program and other health services, they violate Congress' intent that the Title X program be coordinated with, and, where possible, integrated into other health programs.

## ARGUMENT

### STATEMENT OF FACTS[5]

*Scope of the Program*

Title X of the Public Health Service Act, 42 U.S.C. § 300 *et seq.* (Title X), is a program of federal grants to public and private organizations to support family planning projects.[6] Typical recipients of Title X funds are private non-profit health services organizations, such as affiliates of Planned Parenthood Federation, other reproductive health centers, comprehensive community health centers, hospitals and governmental entities such as state, county and city health departments.[7] Pursuant to Congress' intent, the clients served are predominately poor.[8]

5 Throughout this brief, the abbreviation "J.A." refers to the parties' Joint Appendix; "C.A." refers to the Appendix to the Petition for Certiorari and "A" refers to the Appendix set out at the end of this brief. The latter contains affidavits filed in the district court in the case of *Planned Parenthood Federation of America v. Bowen*. *See supra* page 1.

6 Currently Title X supports 3,900 free-standing and hospital based clinics nationwide which collectively serve nearly 4.5 million women per year. Morley affidavit, ¶ 6 (J.A. 224-25).

7 Forrest, *Delivery of Family Planning Services in the United States*, 20 Fam. Plan. Persp. 88, 92 (1988).

8 Title X was intended to insure that no person is denied access to family planning assistance because of his or her inability to pay. *See* Senate Report No. 91-1004, 91st Cong., 2d Sess. 12 (1970), ([the bill] "will enable us to make services more readily available to the more than 5 million poor and near-poor women, who, for the most part, have not been given the opportunity to avail themselves of family planning services. . . ."); House Report No. 91-1472, 91st Cong., 2d Sess. 11 (1970) ("With this legislative action a significant forward thrust can be given to the provision of services to all those who want them but cannot afford them . . ."). The statute



Pursuant to congressional and regulatory design, Title X family planning projects are "comprehensive" in scope. Congressional Declaration of Purpose (1); 42 U.S.C.A § 300, Historical Note. Services offered include counseling, provision of birth control methods, physical examinations, screening and treatment for sexually transmitted diseases, screening for cervical and breast cancer[9], pregnancy testing, treatment of minor gynecological disorders, infertility services, and referral to all medical services not provided by the program. 42 C.F.R. § 59.5 (a)(1), (b)(1) and (2)(1988). *See generally* Program Guidelines for Project Grants for Family Planning Services (1981) (J.A. 67-72).

Title X also funds developing and making available to the public educational and informational materials on family planning and population. 42 U.S.C. § 300a-3(a). Projects funded include libraries which contain resource materials for educators, students and other individuals.[10]

*Abortion in the Title X Program*

Counseling and referral for abortion services are no exception to the broad scope of Title X services. Although Title X projects may not provide abortions, 42 U.S.C. § 300a-6, since the inception of the program professionals have been permitted and encouraged to provide information about abortion provided it is "nondirective."[11] As the official charged with administering the program told the family plan-

requires that projects give assurances that priority will be given to furnishing of services to persons from low income families and no charge be made for services to such persons. 42 U.S.C. § 300a-4 (c)(1) and (2). More affluent patients are charged fees based on ability to pay, and persons who are able pay full fee for services. 42 C.F.R. § 59.5(a)(8).

9 Congress has frequently and favorably cited Title X clinics as important sources of "preventive health care" beyond the provision of contraceptives. *See, e.g.*, House Report No. 95-1191, 95th Cong., 2d Sess. 30 (1978).

10 Galloway affidavit, ¶¶ 18-26 (A-14-A-15).

11 *See, e.g.*, General Accounting Office, Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification (September 24, 1982) (J.A. 107-108).

ning field in 1976, counselors have "not only a First Amendment right but duty to inform a patient of all legal options."[12]

Discussions of pregnancy and abortion are an inevitable and integral part of any program that provides medically-based family planning services.[13] Such discussions arise in many contexts for pregnant and nonpregnant patients.

First, information about the availability of abortion must be given to nonpregnant patients because it is relevant to choice of contraceptive method. Women considering an intrauterine device (IUD) must be counseled that if they become pregnant with the IUD in place, they may have to consider abortion because of the risk of an infection which can be life-threatening.[14] This information may influence the woman's choice of method, but also may be critical in saving her life should she later become pregnant with the IUD in place.[15] A woman choosing other methods of family planning also needs information about the availability of abortion as a backup if contraception fails. For example, women who need highly effective contraception and, for medical reasons, cannot use oral contraceptives or IUDs, may have to choose between permanent surgical sterilization and less effective temporary methods such as the diaphragm or condom. It is relevant to

12 Memorandum from Deputy Assistant Secretary for Population Affairs, Louis Hellman, to Hilary Connor, Regional Health Administrator, DHEW Region VIII (November 19, 1976) (C.A. 74a). 1981 Program Guidelines codified this policy by requiring that women diagnosed as pregnant in Title X clinics be offered nondirective counseling about all options for managing a pregnancy, including abortion, adoption, and keeping the child, and referred to any of those services upon request. Program Guidelines for Project Grants for Family Planning Services (C.A. 71a).

13 The Secretary depicts the new regulations as limiting the Title X program to "preconceptional" family planning services. 42 C.F.R. § 59.2 (1988). While such a limitation might be possible in a program which simply hands out nonprescription methods of birth control, such as condoms, any family planning program which offers prescription methods, which require medical examinations and screening to rule out pregnancy, cannot make such an artificial distinction. *See infra* note 17, and accompanying text.

14 21 C.F.R. § 310.502 (1989).

15 Grimes declaration, ¶ 11 (A22).



such a woman's decision that the effectiveness of the diaphragm or condom is enhanced by the availability of early abortion as a backup should those contraceptives fail and that such abortions carry a comparatively small health risk.[16]

The second major clinical setting for discussion of abortion is when pregnancy is diagnosed. This can occur in the course of the physical examination that must accompany the provision of all prescription contraceptive methods[17]; when a contraceptive provided by the Title X project fails[18]; and when the project provides pregnancy testing to non-family planning patients, a service required by the federal Title X guidelines.[19]

The counseling given pregnant women is voluntary, nondirective and includes all options: abortion, carrying to term and keeping the child, and carrying to term and relinquishing the infant for adoption. Where appropriate, pregnant women are also given information about genetic or congenital problems which could arise, and about steps to take for diagnosis and treatment of these problems. Women are also given information on the importance of early prenatal care, good nutrition, and on dangers to the woman and developing fetus such as cigarettes, certain drugs, alcohol, and environmental hazards. All women are given specific referrals to providers

16 Jones declaration, ¶¶ 12-15 (A-24-A-26); *see also* Sammons affidavit, ¶ 14 (J.A. 267).

17 Program Guidelines, *supra* note 12 at § 8.3 (J.A. 67). Before prescribing oral contraceptives, it is imperative to rule out pregnancy because of the possible adverse effects of the drugs on the fetus, 21 C.F.R. § 310.501 (2)(iv) and (3)(viii)(1989); insertion of an IUD in a pregnant uterus can cause a miscarriage. 21 C.F.R. § 310.502.

18 Failure rates range from user failure rates of 26% for spermicides to 6% for the Pill; Jones and Forrest, *Contraceptive Failure in the United States: Revised Estimates from the 1982 National Survey of Family Growth*, 21 Fam. Plan. Persp. 103, 109 (1989).

19 Program Guidelines, *supra* note 12 at § 8.6 (C.A. 71a). The Guidelines state that pregnancy testing is one of the most frequent reasons for an initial visit to a family planning clinic, particularly for adolescents. "It is therefore important to use this occasion as an entry point for providing education and counseling about family planning." *Id. See, e.g.*, affidavit of Paul Drisgula, ¶ 8 (J.A. 150).

of the health services appropriate to their choices and medical needs.[20]

When a woman's health is endangered by her pregnancy, counseling regarding her options is particularly urgent. Such situations include diabetes, cardiac disease, certain cancers, and pregnancy with an IUD in place which cannot be removed. In these instances a physician must advise a woman that abortion is an option she should consider and, if she should so choose, provide her with an immediate referral to a provider of abortion services.[21] Delay in seeking services in these situations can lead to increased health risks, both from later abortions and from the woman's worsening medical condition.[22] Prompt counseling and referral are also critical when a fetus may be affected with a genetic or congenital disorder. For example, a woman who carries the HIV virus which causes AIDS needs to know as early as possible the chances that the virus will be transmitted to the fetus so that she can avail herself of a safe early abortion if she so chooses.[23]

Title X projects also provide factual information about abortion in educational materials regarding family planning, reproductive health and sexuality. Title X supported libraries contain books on the history and medical aspects of abortion.[24]

All the foregoing is information Title X projects were until now permitted and encouraged to provide as part of a comprehensive, ethical and medically sound[25] family planning program. The new regulations radically change all this, replacing good health care and unbiased informational services with censorship and propaganda.

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20 Program Guidelines, *supra* note 12 at § 8.6, (C.A. 71a). Clark declaration, ¶¶ 5-6 (A-2); Vernon declaration, ¶ 6 (A-28); Galloway declaration, ¶¶ 9-10 (A-18); Jones declaration, ¶ 6 (A-25).

21 Grimes declaration, ¶¶ 9,10 (A-21-A-22).

22 *Id.* at ¶¶ 8,9,10.

23 *Id.* at ¶ 12.

24 *See, e.g.*, Galloway declaration, ¶¶ 18-26 (A-14-A-15).

25 Sammons affidavit (J.A. 260-69); Morley declaration (J.A. 223-31).



***The New Regulations***

Under the new regulations, personnel in Title X projects are barred from discussing abortion with pregnant patients or even telling a woman where legal abortions are available. Even in response to specific questions, providers may answer only that the Title X project "does not consider an abortion an acceptable method of family planning." 42 C.F.R. § 59.8(b)(5). The prohibition applies regardless of the woman's medical condition (except for emergencies), her risk for transmitting congenital or genetic disorders to the fetus, or her expressed preference.

Instead of counseling and referral appropriate to each patient's needs, *all* pregnant women must be handed a list of providers of prenatal care and/or social services which "promote the welfare of mother and unborn child." 42 C.F.R. § 59.8(a)(2). No provider whose principal business is provision of abortion services may be included on the list and the list *must* include providers of prenatal care or social services that do not provide abortions. *Id.* at § 59.8(a)(3) and (b)(4). Title X projects may not identify abortion providers on the list or those agencies likely to provide information about abortion, including their own separately-funded programs that provide such information.[26]

Discussion of abortion in the contraceptive context is limited to provision of information medically necessary to assess the risks and benefits of contraception but which does not constitute counseling with respect to abortion or promotion of abortion as a method of family planning. *Id.* at § 59.8(a)(4). The examples that accompany this provision indicate it will be narrowly construed to allow only the handing to the woman of printed materials, such as the chart which federal law used to require as part of the patient package insert for oral contraceptives, unaccompanied by discus-

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26 Many entities which receive Title X funds also operate other health care services, including abortion services. General Accounting Office, Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification (September 24, 1982) (J.A. 85). *See* discussion *infra* page 29.

sion, explication or counseling. *Id.* at § 59.8(b)(6).[27] This provision of the regulations, moreover, leaves no room at all for warning a woman that if she becomes pregnant with an IUD in place, she should be prepared to consider an abortion, a warning required elsewhere under federal law and one which may save her life. *See* 21 C.F.R. § 310.502 (1989).

The ban on counseling and referral applies to private as well as public funds within the Title X project. For example, patients who pay full fee for their services may not receive the prohibited information, and privately raised "matching funds" may not be used to provide the prohibited services. 42 C.F.R. § 59.2.

Moreover, neutral educational and informational materials regarding abortion may no longer be supplied through a Title X project, including its libraries, because such materials are now viewed as "encouraging or promoting abortion." *Id.* at § 59.10 (a)(5).

***Effect of the New Regulations***

The new regulations' prohibition on the utterance of information about abortion effectively deprives women of information they need to make critical health care decisions. It is unlikely that women will simply go elsewhere for this information. Congress created the Title X program in recognition of the fact that it would provide poor people access to services available to them nowhere else. Even if it were easy for women who know they want abortions to find alternative sources of information, the regulations apply in situations where women will not be able to perceive their own needs. For example, women with health threatening pregnancies confronted with their physicians' silence have no way of knowing other services should be searched out. The result can only be increasingly complicated pregnancies and poor maternal and fetal health.[28]

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27 This patient package insert for oral contraceptives used to be required to contain a chart comparing the risks of barrier methods backed up with early abortion to the risks of the Pill. 42 Fed. Reg. 4214 *et seq.* (1978). The FDA dropped the requirement that this information be included in the patient package insert in February, 1988.

28 Grimes declaration, ¶ 9 (A-21).



The situation is worsened by the addition of propaganda: the requirement that the woman be provided with a list of providers of prenatal care. It is unlikely that a woman seeking an abortion will get the information or services she needs from any provider on the list. Worse still, the provision of the list to her will be affirmatively misleading, encouraging her to embark on a confusing and fruitless search, one which could seriously endanger her health.

Providers of abortion services poor women can afford are not likely to be on the list. This is because most abortions and nearly all moderately priced services are provided at clinics which would be excluded from the list because they specialize in abortion services or do not provide prenatal care.[29] Hospitals as providers of abortion services have become increasingly scarce.[30] Those that do exist tend to provide abortions at prices beyond the reach of most Title X patients[31] and under restricted circumstances: for example, only in cases of fetal abnormality or when there is a threat to the woman's life.[32]

Nor is it likely women will obtain adequate or timely informational services from the agencies on the list. Prenatal care clinics assume their clients have wanted pregnancies and, consequently, are not set up to offer counseling or referral for

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29 Henshaw declaration, ¶ 12 (J.A. 192). For example, virtually all abortions in the State of Utah are performed in two specialized abortion clinics which would be disqualified from the list. Second Galloway declaration, ¶ 3 (A-16-A-17). In Colorado 78.7% of all abortions are performed at eight specialized clinics ineligible to appear on the list. Second Clark declaration, ¶ 2 (A-2). *See generally*, Henshaw and Van Vort, *Abortion Services in the United States, 1987 and 1988*, 22 Family Planning Perspectives 102 (1990) (increasingly high percentage of the nation's abortions are performed in specialized abortion clinics).

30 *Abortion Services in the United States, supra* note 29 at 107 (number of hospital providers dropped from 1,654 in 1977 to 1,040 in 1988).

31 A hospital abortion, even one performed on an outpatient basis, costs three to four times as much as an abortion in a free-standing clinic. Henshaw, *Freestanding Abortion Clinics: Services, Structure, Fees*, 14 Family Planning Perspectives 248, 255 (1982).

32 *See, e.g.*, Second Galloway declaration, ¶ 3 (A-16-A-17).

other options.[33] In fact, many refer to Title X clinics for pregnancy counseling.[34] Because low cost prenatal care services are scarce, there may be a wait as long as ten weeks for a first appointment.[35] Moreover, the regulations provide that social service agencies which promote the welfare of unborn children but provide no abortions be placed on the list; this virtually insures the inclusion of so-called "right to life" problem pregnancy centers whose stated mission is to steer women away from abortion.[36]

Even if the list included a provider that would provide prompt information, the woman has no way of obtaining that information in an efficient manner. Title X personnel are forbidden to identify those organizations on the list that provide abortion information, tell a woman whom to speak to at an organization to obtain help with abortion, or otherwise how to go about getting the advice she needs. Moreover, even if the agency which operates the Title X project also operates a totally separate informational service with private funds, Title X project personnel may not tell the woman about the existence of that service.

The result of the provision of this confusing and irrelevant information is that, at the least, women will be delayed in obtaining the health care they want and need.[37] Even for healthy women, delay in obtaining an abortion leads to increased health risks.[38] For women whose health is adversely affected by continued pregnancy, the delay can mean serious health damage, even death.[39]

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33 *See, e.g.*, Second Clark declaration, ¶ 7 (A-7); Second Galloway declaration, ¶¶ 5,6,7 (A-17-A-18); Second Durgin declaration, ¶ 4 (A-9).

34 *See, e.g.*, Second Durgin Declaration, ¶ 4 (A-9).

35 Second Clark declaration, ¶ 8 (A-7); Second Durgin declaration, ¶ 5 (A-10) (wait of three weeks for counseling appointment with health department or community clinic).

36 *See, e.g.*, Second Clark declaration, ¶¶ 11, 12 (A-7).

37 *See, e.g.*, Second Galloway declaration, ¶ 7 (A-18).

38 Grimes declaration, ¶ 8 (A-21).

39 *Id.*, ¶ 9 (A-21).



At the worst, a woman denied information and treated to the referral runaround will have her choice completely denied. Abortions become more expensive the later they are obtained and poor women may simply be unable to afford the increased cost that results from delay.[40] Providers willing to perform second trimester abortions are scarce[41] and after a certain point, abortions are no longer legally available.

Title X patients are particularly vulnerable to these restrictions. Because of poverty or youth[42], they already tend to delay identifying their pregnancies and seek abortions later than affluent or mature women.[43] Moreover, they are disproportionately affected by diseases such as AIDS that can complicate their health and the health of the fetus.[44] By definition, they are dependent on subsidized services for information and counseling.[45] The regulations turn a program

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40 *See, e.g.*, Second Galloway declaration, ¶ 10 (A-18-A-19). (In Utah, prices for abortions rise from $200 in the first trimester to $900 at 20-21 weeks of pregnancy.) The states generally provide no subsidies for the cost of abortion services, while childbirth is universally subsidized.

41 Henshaw, *et al.*, *Abortion Services in the United States, 1984-85*, 19 Family Planning Perspectives 63 (1987). *See, e.g.*, Second Galloway declaration, ¶¶ 3, 10 (only one clinic in the State of Utah performs second trimester abortions) (A-16-17, A-18-19).

42 Fourteen percent of Title X patients are minors. *Delivery of Family Planning Services in the United States, supra* note 7 at 92. The statute mandates "services for adolescents." 42 U.S.C. § 300(a).

43 Clark declaration, ¶ 9 (A-3); Morley declaration, ¶ 12 (J.A. 227). The majority of legal abortions performed at or after 16 weeks gestation, are performed on 15 to 19 year olds although women in this age group accounted for only 24% of all abortions. Centers for Disease Control, CDC Surveillance Summaries, June 1990. MMWR 1990; 39 (No. SS-2), p. 53, Table 19, Number and percentage of reported legal abortions, by weeks of gestation, procedure, age group, and race, 1986.

44 Morley declaration, ¶ 16 (J.A. 228); Joseph declaration, ¶¶ 6-8 (J.A. 198-99).

45 In some communities, the Title X clinic is virtually the *only* provider of subsidized care. *See, e.g.*, Clark declaration, ¶ 12 (A-3-A-4); Galloway declaration, ¶ 2-4 (A-11). Since many providers will not accept Title X funds under the unethical restrictions imposed by the regulations, they will be forced to close or drastically curtail services, depriving poor women of their

intended to aid the poor by enhancing their life choices[46] into an assault on the very people and rights it was meant to protect.

## I. THE REGULATIONS' COUNSELING AND REFERRAL BAN SUPPRESSES INFORMATION AND COERCES CHOICE IN VIOLATION OF THE FIRST AMENDMENT

The new regulations' combination of censorship and propaganda effectively suppresses information in violation of Title X patients' first amendment rights. Although the government may decide what to subsidize, it may not manipulate programs like Title X so as to suppress ideas and information. The Title X regulations do this by hiding information and compelling provision of irrelevant information in a context in which individuals are particularly reliant for full information and advice: the relationship between health care professional and patient.

### A. The First Amendment Protects The Right To Receive Information

As this Court has said, "Freedom of speech presupposes a willing speaker. But where a speaker exists, . . . the protection afforded is to the communication, to its source and to its recipients both." *Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council*, 425 U.S. 748, 756 (1976). This Court has also made abundantly clear that the right to receive information is not confined to political information, but includes all matters of public concern. It includes the right to receive information about prescription drugs, *Virginia Board of Pharmacy*, 425 U.S. 748; lawyers' fees, *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977); sale of housing, *Linmark Associates v. Willingboro*, 431 U.S. 85 (1977); contraception, *Carey v. Population Services International*, 431 U.S. 678 (1977) and *Bolger v. Youngs Drug Products Corp.*, 463 U.S. 60 (1983); and abortion, *Bigelow v. Virginia*, 421 U.S. 809 (1975).

sole source of family planning services. Clark declaration, ¶ 12 (A-3-A-4); Galloway declaration, ¶¶ 7,8 (A-12); Vernon declaration, ¶¶ 14,15 (A-28-A-29).

46 *See, e.g.*, Senate Report No. 91-1004, 91st Cong., 2d Sess. 12 (1970) (Title X addresses the need of the poor to exercise their right to determine the size and spacing of their families.)



The constitutional protection for the right to receive information does not exist in a vacuum. Its purpose is to insure that individuals make critical life decisions in an informed and intelligent manner. *See Cohen v. California*, 403 U.S. 15, 24 (1971) (no other system protects the "individual dignity and choice upon which our political system rests"). When governmental restrictions block the flow of information necessary or even useful to make such decisions, the first amendment is violated.

Justice Rehnquist's concurring opinion in *Bolger v. Youngs Drug Products*, 463 U.S. 60, recognizes that the first amendment right to receive information safeguards the integrity of decisions regarding family life and reproductive health similar to those at issue here. In that case he agreed that the Postal Service's ban on contraceptive advertising was unconstitutional because it denied "parents access to information about birth control that might help them make informed decisions" in directing their children's education regarding the use of contraception. *Id.* at 79. In so doing, he noted the connection between the first amendment's protection of the free flow of information and individual autonomy:

> The First Amendment, which was designed to prevent the Government from suppressing information, requires us 'to assume that this information is not in itself harmful, that people will perceive their own best interests if only they are well enough informed, and that the best means to that end is to open the channels of communication rather then to close them.'

463 U. S. at 79 (Rehnquist J., with whom O'Connor J., joins, concurring) (quoting *Virginia Board of Pharmacy*, 425 U.S. at 770). *See also Cruzan v. Director, Missouri Department of Health*, No. 88-1503, 58 U.S. Law Week 4916 (June 26, 1990) (recognizing an individual's liberty interest in informed consent).

The Title X regulations strike at the heart of these first amendment principles. Rather than treating women like the parents in *Bolger*—free agents who must be permitted to perceive their own best interests on the basis of full information—they manipulate the provision of information so as to distort perception and remove choice. They do this by censoring truthful information about abortion and compelling provision of what for some women is irrelevant information about prenatal care, so that women are delayed or blocked in their ability to resolve a problem pregnancy. Such a system could not be more adverse to the first amendment. *Central Hudson Gas and Electric v. Public Service Commission*, 447 U.S. 557, 574-75 (1980) (Brennan, J., concurring) (state's attempt to manipulate its citizens' choices by withholding information strikes at the "heart" of the first amendment). *Linmark Associates v. Willingboro*, 431 U.S. at 96 (government may not withhold information in order to influence a person's decision about where to live).

### B. The Government May Not Manipulate Subsidy Programs So As To Have A Significantly Coercive Effect On The Receipt Of Information

Although the regulations impose restrictions in the context of a program of government subsidies, the first amendment violation is not diminished. Although the government may decide how to spend its money, it may not manipulate its subsidy programs so as to have a "significant coercive effect" on the exercise of first amendment rights. *Arkansas Writers' Project v. Ragland*, 481 U.S. 221, 237 (1987) (Scalia, J., with whom the Chief Justice joins, dissenting).[47]

In determining whether restrictions in a government subsidy program have a "significant coercive effect" on constitutional rights, this Court has utilized both a formal legal and a practical analysis. The formal legal analysis looks to whether the restrictions affirmatively block the exercise of rights or, instead, merely leave in place an impediment to their exercise, such as poverty, which the government did not create. In other words, does the funding restriction leave a person in the same position he or she would be in if there were no subsidy program at all? For example, in *Lyng v. International Union, U.A.W.*, 485 U.S. 360 (1988), this Court said denial of food stamps to strikers did not interfere with the strikers' first amendment right to associate. The denial simply failed to alleviate the inevitable economic hardship that comes with striking. Strikers were certainly not affirmatively harmed by the very existence of the food stamp program. *See also Taxation With Representation*, 461 U.S. 540 (failure to grant a tax exemption for lobbying does not impede an organization's right to lobby); *Harris v. McRae*, 448 U.S. 297 (1980) (by refusing to fund abortions, government simply fails to alleviate the hardships of poverty; it leaves women free to choose whether or not to have an abortion with their own funds).

The existence of a more factually based, practical analysis has been implied in a number of cases. In *Lyng*, the Court said the denial of food stamp benefits was "exceedingly unlikely" to prevent individuals from continuing to associate together in unions. 485 U.S. at 366 (quoting *Lyng v. Castilla*, 477 U.S. 635 (1986)). Similarly, In *Arkansas Writers' Project v. Ragland*, 481 U.S. 221 (1987), Justice Scalia noted in his dissenting opinion that it was "implausible" that Arkansas' failure to exempt certain publications from a 4% general sales tax was either meant to inhibit or had the effect of inhibiting those publications. *Id.* at 237 (Scalia. J, dissenting). And in *Regan v. Taxation with Representation*, 461 U.S. 540 (1983), this Court upheld a denial of tax exemption for a charity's lobbying activities because the organization was free to lobby through a wholly controlled ancillary corporation. *Id.* at 544 n.6. *See also FCC v. League of Women Voters*, 468 U.S. 364, 400 (1984) (statute would be valid that banned public radio stations from editorializing but allowed

47 This Court's opinions indicate that subsidy restrictions "aimed at the suppression of dangerous ideas" are invalid on their face without reference to their coercive impact. *Regan v. Taxation with Representation*, 461 U.S. 540, 550 (1983); *FCC v. League of Women Voters*, 468 U.S. 364, 407 (1984) (Rehnquist, J., dissenting). Although *amici* believe that that test applies to the speech at issue here, they believe the regulations fall under the more stringent test of "significant coercive effect" as well and address their brief to that issue.

establishment of a privately funded affiliate which could editorialize while sharing the public station's facilities).

### C. The Regulations Have A Significant Coercive Impact On The Right To Receive Information

Applying these tests, the Title X regulations are unconstitutional. Denial of information about abortion and compelled receipt of information about prenatal care does not leave women in the same position they would be if there were no Title X program at all. Rather, by accepting the government's offer of aid, they are affirmatively harmed. Moreover, as a practical matter it is "exceedingly unlikely" that Title X patients will, as a result of the regulations' manipulative provision of information, be able to obtain the information they need to protect their health and life choices. *Cf. Lyng*, 485 U.S. at 366.

The coercive effect of the regulations arises in part out of the design and purpose of the Title X program. Title X is an aggressive program of government outreach and support for expanded family planning services.[48] Throughout the program's history Congress and DHHS have set goals for pre-

48 Title X has been described as a "major new congressional initiative in the field of population research and family planning" with a goal to "*expand the availability* of voluntary family planning services with priority on low income people." House Report No. 95-1191, 95th Cong., 2d. Sess. 28 (1978) (emphasis added). The statute itself requires that each fiscal year the Secretary make a report to Congress on a plan for *extension of family planning services to all persons desiring such services*. 42 U.S.C. 300a-6a (a)(1) (emphasis added). All projects participating in the Title X program must provide assurances to the Secretary that they will develop informational and educational programs designed to (i) achieve community understanding of the objectives of the Title X program, (ii) inform the community of the availability of services, and (iii) promote continued participation in the Title X project by persons to whom family planning services may be beneficial. 42 C.F.R. § 59.5 (b)(3). The Department's Program Guidelines, *supra* note 12, at § 6.11 require that all projects "establish and implement planned activities whereby their services are made known to the community" in order to promote "community acceptance of and access to family planning services."



vention of unintended pregnancy[49] and Congress has taken pride year after year in the increasing number of persons reached with the services.[50] The government reached out to poor women with an irresistible invitation: "If you are unable to afford, or are scrimping to pay for family planning services, or buying over-the-counter products with no medical back up, come to our clinics where you will receive medically complete comprehensive services."

But, unlike the strikers in *Lyng*, left in the same position by their exclusion from the food stamp program as they would have been if there were no program at all, women heeding the siren call of the Title X program will be affirmatively harmed by their acceptance of government aid. A woman is worse off in the clutches of the "new" Title X program than she would be if she ignored or never heard the government's offer, and sacrificed to pay for her own medical care or got no medical family planning care at all.[51]

Had a Title X patient ignored the government's invitation and scraped together the funds to pay a private doctor for family planning services and been diagnosed as pregnant[52],

49 The Secretary's five year plan for family planning services must include on a phased basis, "the number of individuals to be served by family planning programs under this subchapter" and the Secretary's progress in meeting the goals of the previous year. 42 U.S.C. § 300a-6a (b)(1) and (c)(1).

50 For example, the House Committee on Interstate and Foreign Commerce's report on reauthorization of Title X cited the program's "impressive achievement" of reaching 4 million low- and marginal-income women, including 1.2 million teenagers, but nevertheless estimated that an additional three million women and two million sexually active teenagers needed services. It therefore authorized an increase in appropriations to "reaffirm its commitment to a nationwide, *targeted* family planning services program." House Report No. 95-1191, 95th Cong., 2d Sess. 29, 31 (1978) (emphasis added).

51 Moreover, once a poor woman whose marginal income makes her ineligible for free services has spent her scarce resources on the inadequate care which will be provided at Title X clinics, she may be unable to find additional funds for private care. *Commonwealth of Massachusetts v. Bowen*, 899 F.2d 53, 70 (1st Cir. 1990). *See supra* note 8.

52 The government says that the Title X regulations are simply denying a subsidy for the "service" of abortion counseling and referral. As

she would have received, consistent with her doctor's legal and ethical obligations, information about all options for managing her pregnancy, and referral upon request for an abortion, even if the physician did not provide it.[53] Moreover, if in the course of examining the patient, a medical problem was identified that made abortion an alternative the woman should consider, the physician would have discussed that.[54] A woman accepting the government's offer of help is, without warning[55], denied this critical information.

Moreover, even if the woman had gotten no family planning care at all and experienced an unplanned pregnancy, she would be in a better position to ascertain her medical status and/or find an abortion provider. "Unassisted" by the Title X program, she would not be confronted with a confusing list of prenatal care providers through which she would pursue a frustrating and fruitless search for the services she needed. *See* Statement of Facts, *supra* pp. 11-12.

Most poignantly, a woman with a medically complicated pregnancy who at the beginning of that pregnancy got no care or treatment would be *more likely* to seek out medical care if symptoms later arose, than had she received the biased consultation mandated by the Title X regulations which would have hidden from her the severity of the problems and the need to seek help.

The coerciveness of this scheme arises out of the fact that it is imposed within a relationship which persons rely on for and in which they expect complete and unbiased advice and information, rendered in their best interest: the relationship

explained in the Statement of Facts, *supra*, this is not a separate service but an integral part of a family planning program.

53 Morley declaration, ¶ 19 (J.A. 229-30); Sammons affidavit, ¶ 15 (J.A. 267).

54 Morley declaration, ¶ 17 (J.A. 228-29); Sammons affidavit, ¶¶ 10, 11, 12, 15 (J.A. 267).

55 No posted disclaimer could adequately warn a woman of the information she will *not* receive. *See infra* p. 21.



between health practitioner and patient.[56] The regulations betray this trust because there is no meaningful disclaimer that could adequately warn women of the perils they are about to encounter. Even a sign in the clinic saying "abortion not discussed here" would be meaningless to a patient who needs an abortion for health reasons because she has no way of knowing that abortion is an option she should consider. Similarly, a woman not warned to consider abortion if she suspects pregnancy with an IUD in place will have no clue that such a sign applies to her.

By, without warning, censoring information expected in a health care relationship and compelling the receipt of irrelevant, inappropriate information, the Title X regulations leave women worse off than they would be if they had never entered the door of a Title X clinic. Their right to receive the information necessary to make critical life choices has been affirmatively and effectively suppressed.

Much of the preceding discussion applies to any "practical" test for the coercive impact of subsidy denials. Unlike the strikers in *Lyng* who were not likely to give up striking solely because of a denial of food stamps, it is "exceedingly unlikely" that women subjected to the Title X regulations will find the information they need. As a practical matter, the agencies on the referral list are not set up to provide the options counseling formerly provided in Title X clinics. *See* Statement of Facts, *supra* pp. 11-12. Even were they to change operations, there is no way under the regulations for Title X personnel to direct the women to the agencies that will give them appropriate information, even to those services run with private funds by the Title X project's parent agency. Finally, Title X patients are uniquely vulnerable to the denial of information because they are by definition dependent on

56 In this sense the Title X regulations must be distinguished from the situation where the government decides to fund speeches at the Kennedy Center on music but not on politics, *see* 20 U.S.C. § 76n(a) (cited in *Arkansas Writers' Project*, 481 U.S. at 238 (Scalia, J., dissenting)), or billboards expressing government viewpoints. Listeners to those types of speech understand them as biased and expect to be and are free to seek out other viewpoints. Moreover, they are not dependent on the information they receive to make critical life decisions.

the Title X program for family planning care, and disproportionately suffer from pregnancy complications and delay in obtaining help with their pregnancies. *See* Statement of Facts *supra* p. 13.

Both as a formal legal and a practical matter the regulations have a significant coercive effect on the right to receive information and must be held unconstitutional.

## II. THE REGULATIONS VIOLATE THE RIGHT TO PRIVACY

Because they impermissibly restrict the flow of information that a woman must have to make an informed decision whether to have an abortion, the regulations "constitute an 'unduly burdensome interference' with a woman's freedom to decide whether to terminate her pregnancy," and therefore violate the right to privacy. *Planned Parenthood Federation of America v. Bowen*, 680 F. Supp. at 1474 (quoting *Maher v. Roe*, 432 U.S. 464, 473-74 (1977)). *Accord Commonwealth of Massachusetts v. Bowen*, 899 F.2d at 65.

The government has claimed throughout this litigation, and in other identical cases, that *Maher v. Roe*, 432 U.S. 464 and *Harris v. McRae*, 448 U.S. 297 authorize the regulations. In *Maher* and *Harris* this Court approved governmental decisions not to pay for poor women's abortions because such a denial imposed no affirmative obstacle in the path of a woman needing an abortion; it simply failed to remove one not of the government's creation: the woman's poverty. As described in Point I, however, these regulations do much more than passively fail to alleviate the disabilities of poverty; they affirmatively and aggressively interfere with choice. The Medicaid program of government aid for health care dealt with in *Maher* and *Harris* did not harm pregnant women. That subsidy denial left them with the same range of choices in deciding whether to have an abortion that they would have had if the government never set up the Medicaid program. *Harris*, 448 U.S. at 317. In contrast, a pregnant woman who enters the doors of a Title X clinic is worse off for having accepted the government's help. She will be delayed in getting the health care she needs and her right to



that care may be altogether lost. The regulations, therefore, violate the right to privacy.

## III. THE REGULATIONS ARE NOT RATIONALLY RELATED TO ANY LEGITIMATE GOVERNMENT PURPOSE

Obstacles to the effectuation of fundamental rights, such as the first amendment and privacy rights at issue here, must be subjected to strict scrutiny and justified by a compelling state interest. *See, e.g., Roe v. Wade*, 410 U.S. 113 (1973) (right to privacy); *Boos v. Barry*, 485 U.S. 312 (1988) (content based speech restrictions). There is no need to apply that judicial test here, however, as the regulations do not meet the most minimal level of judicial scrutiny: that they be rationally related to a legitimate government end. *Hodgson v. Minnesota*, Nos. 88-1125 and 88-1309, slip op., 58 U.S.L.W. 4957, 4968 (June 26, 1990) (O'Connor, J., concurring). Whatever the purpose of these regulations—whether it is to dissuade women from having abortions or not to "promote or encourage abortion" in the Title X program—the censorship and propaganda of the regulations cannot be a rational means to that end. If the "rational basis" test means anything, it must be that government may not accomplish its ends by suppressing information[57], for to do so strikes at the heart of our status as a free people. The choice "between the dangers of suppressing information, and the dangers of its misuse if it is freely available" is not a choice the government may make, for it is a choice "that the First Amendment makes for us." *Linmark Associates*, 431 U.S. at 97 (quoting *Virginia Board of Pharmacy*, 425 U.S. at 770). No other system protects the "individual dignity and choice" upon which our democracy rests. *See Cohen v. California*, 403 U.S. 15, 24 (1971).

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57 *But c.f. Near v. Minnesota*, 283 U. S. 697, 715-16 (1931) (information may be suppressed in time of war or national emergency). The Secretary has cited no evidence to indicate that counseling or referral services under present Title X policies are being abused so as to promote or encourage abortions or advocate abortion. In fact, the report of the General Accounting Office's extensive audit of Title X program exonerated Title X clinics of any such charge. Restrictions on Abortion, *supra* note 26 (J.A. 86).

## IV. THE NEW REGULATIONS VIOLATE THE TITLE X STATUTE

The new regulations are clearly inconsistent with two statutory mandates.[58] They contain a brand new definition of "Title X project funds" to "include all funds allocated to the Title X program, including but not limited to grant funds, grant-related income or matching funds." 42 C.F.R. § 59.2. This definition extends the statutory abortion prohibition, 42 U.S.C. § 300a-6, beyond the limits intended by Congress.

The second mandate arises through consistent and emphatic legislative history, expressing Congress' intent that a Title X program be closely coordinated with other health services and, if possible, fully integrated into larger comprehensive health care programs, including those run by the same organization which receives Title X funds. The purpose of this mandate is to provide an efficient program that acts as an entry point into the primary health care system for poor women. This mandate is violated by the referral prohibitions of 42 C.F.R. § 59.8 and the separation requirements of § 59.9.

### A. The Definition Of Title X Project Funds Violates The Statute

Section 300a-6 states that none of "the funds appropriated" under Title X may "be used in programs where abortion is a method of family planning". Congress made clear, however, that prohibition was not to extend beyond the Title X program.

> [Section 300a-6] does not and is not intended to interfere with or limit *programs* conducted in accordance with State or local laws and regulations which are supported by funds other than those authorized under this legislation.

Conference Report No. 91-1667, 91st Cong., 2d Sess. 8 (1970) (emphasis added).

58 *Amici* fully agree with the other statutory arguments made by the plaintiffs/appellants in this case.



The exact parameters of each grantee's Title X program or project are set by statute. A Title X "program" consists of federally appropriated Title X funds which may be no less than 90 percent (90%) of the program's budget[59] and a ten percent (10%) "match" supplied by the recipient. 42 U.S.C. § 300a-4(a). Any funds raised by the recipient exceeding this 10% match are, therefore, outside the scope of the "program".

The new regulations contravene this statutory requirement. They define a Title X project to include Title X appropriated funds, the recipient's ten percent (10%) share, and virtually all other grant-related and program income received by a Title X grantee, including patient fees, reimbursement through third parties such as Medicaid, etc. 42 C.F.R. § 59.2. The regulations therefore, extend the prohibitions of 42 U.S.C. § 300a-6 beyond the Title X program as Congress has precisely defined it to other revenue associated with family planning activities conducted by a recipient. This violates Congress' intent that the abortion prohibition be confined to the limits of the Title X program.[60]

59 This requirement of a minimum federal contribution is unique among federal grant statutes, which usually place the burden on the recipient to match the federal share. In contrast, under Title X, the burden is on the government to provide a minimum percentage of the costs of a program. *See, e.g.*, Medicaid, 42 U.S.C. § 1396 *et seq.*; the Adolescent Family Life Demonstration Projects, 42 U.S.C. § 300z *et seq.*; and NIH alcohol and drug abuse research grants, 42 U.S.C. § 290bb *et seq.*

The government however rarely meets this obligation. In oral argument before the U.S. Court of Appeals for the First Circuit in *Commonwealth of Mass. v. Secretary of Health & Hum. Serv.*, 899 F.2d 53, counsel for the Secretary indicated that Title X recipients generally supplied fifty percent (50%) of the total funds associated with their family planning costs—considerably more than is required by the statute. 899 F.2d at 73 n.11. Affidavits in the case before this court provide confirmation. *See, e.g.*, Affidavit of Joan Coombs (J.A. 141) (Planned Parenthood of New York City, Inc. receives approximately 27% of its operating budget for its clinic at the HUB, its center in the South Bronx, from Title X appropriated dollars); Affidavit of Kathleen Murray (J.A. 239) (Deaconess Family Planning Program's Title X funding would total 34% of the program's budget).

60 In so far as the statute does impose the abortion prohibition on the recipient's private funds within the 10% match, the statute itself may be unconstitutional. *Commonwealth of Mass.*, 899 F.2d at 74.

### B. The New Regulations Violate Congress' Intent That Title X Projects Be Coordinated And Integrated With Other Health Care Programs

The new regulations prohibit a health care professional from freely providing referral to a pregnant patient based on her medical needs and wishes. 42 C.F.R. § 59.8. In addition, § 59.9 requires not only financial but also physical separation of activities allowed from those prohibited under the new regulations. These requirements violate Congressional intent that Title X programs be coordinated with other health care programs and, where possible, integrated with general health care programs.

The importance of comprehensive services, integrated into a total health care program, was recognized by Congress from the beginning of the Title X program. At the time of Title X's original enactment, the Senate Committee on Labor and Public Welfare stated that it did not view "family planning as merely a euphemism for birth control. It is properly a part of comprehensive health care and should consist of much more than the dispensation of contraceptive devices." S. Rep. No. 91-1004, 91st Cong., 2d Sess. 10 (1970). According to the Committee, the Title X program should include:

> Medical services, including consultation, examination, prescription and continuing supervision, supplies, instruction and *referral to other medical services as needed* . . . [an] outreach/follow-up system, including patient identification, contact, recruitment, appointment support, follow-up, and continuing education.

*Id.* (Emphasis added). The House-Senate Conference Report reflected this concern in stating that Title X's abortion prohibition was "not intended to interfere with or limit programs" supported with non-Title X funds. Conf. Rep. No. 91-1667, 91st Cong., 2d Sess. 5082.

Soon after Title X was enacted, DHHS explained the reason for these requirements of referral and coordination:

> While the program cannot provide full medical care because of its specialized nature, services should be provided for the screening and referral, including follow-up,



> of the patient to appropriate physicians, hospitals or other programs for necessary treatment. *This mechanism is vital, given the fact that family planning is often the point of entry into a fragmented health care system for many individuals*[61] (emphasis added).

By 1975, Congress' concerns had broadened to include integration of family planning programs into general health care programs. Title X had, by that time, become *the* federal family planning program, having absorbed other related federal programs. The report of the Senate Labor and Public Welfare Committee for the 1975 reauthorization states that:

> The Committee believes that comprehensive health care programs, particularly those concerned with maternal health, should include family planning in the services they routinely provide, and stresses that it is essential that there be close coordination and, *whenever possible, integration of family planning services into all general health care programs.* In addition, the Committee believes that family planning services under Title X generally are most effectively provided in a general health setting and thus encourages coordination and integration into all programs offering general health care.

S. Rep. No. 94-29, 94 Cong., 1st Sess. 54, *reprinted in* 1975 U.S. Code Cong. and Ad. News 517 (emphasis added). Thus, Congress made clear that Title X programs were not merely to be coordinated with, *but integrated into*, such programs as Medicaid (42 U.S.C. § 1901 *et seq.*), Maternal and Child Health (42 U.S.C. § 701 *et seq.*), and community health (42 U.S.C. § 254c *et seq.*). *See also* S. Rep. No. 95-102, 95th Cong., 1st Sess. 26 (1977).

These coordination and integration requirements are completely eviscerated by the referral prohibitions of § 59.8(a)(2)

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61 Report of the Secretary of Health, Education and Welfare Submitting Five Year Plan for Family Planning Services and Population Research Program, Special Subcommittee on Human Resources, Senate Committee on Labor and Public Welfare, 92d Cong., 1st Sess. 318 (Comm. Print October 1971) (J.A. 41). The same report included abortion referral "where appropriate" as a "Preferred Standard of Medical Care." *Id.* at 329, 333.

as well as the physical and financial separation requirements of § 59.9.

The referral prohibitions violate both the coordination and integration requirements. The Title X recipient's inability to refer a pregnant patient for appropriate care violates the Congressional intent that the Title X program be coordinated with other providers, in recognition of the fact that the utilization of family planning services is often an entry point into a fragmented health care system for poor women. The Title X provider's inability to refer to its own privately funded counseling service violates the mandate that Title X projects be integrated into existing health care programs. Rather than fostering such integration, the regulations require that Title X personnel merely provide the client with a list of providers who "promote the welfare of mother and unborn child" and send her from the recipient's offices with that list in hand. At best, the recipient's separate counseling service[62] would be one of numerous other providers on the list, and the client's use of that service would occur by mere statistical happenstance.[63]

The physical and financial separation requirements also make it clear that a recipient's options counseling service would have to be a completely independent one from family planning activity. Such an obviously expensive undertaking is rendered impracticable in the first instance, since much of the recipient's private income from fees and grants is appropriated by the new definition of grant-related income.[64] 42

62 This argument assumes the recipient could find funds to pay for such counseling. This is problematic because the new regulations greatly expand the definition of funds subject to the abortion prohibition. *See supra* pp. 24-25.

63 The appearance of an options counseling service on the list is itself problematic, since such a service might not, under the new regulations, be one which "promotes the welfare of mother and unborn child." 42 C.F.R. § 59.8(a)(2).

64 Most recipients use Title X dollars in an overall family planning program. In those situations, the new definition of "Title X program" appears



C.F.R. § 59.2. Similarly, the separation requirements completely undermine coordination and integration by indicating that an entirely discrete system of records and separate personnel will be necessary for the counseling service to fulfill the requirements of § 59.9.

The practical effects of the new regulations must be understood in light of the nature of the recipients of Title X funds. Of 3,900 clinics nationwide that provide Title X services, approximately 1700 are part of county health departments.[65] A smaller percentage are community health centers, receiving additional federal funds under Section 330 of the Public Health Service Act. These entities provide a range of outpatient services to the same population targeted by the Title X program. To provide this broad range of services, they use the same staff, under one roof, with one central record system. If a woman goes into a health center or health department for medical services, and some problem or condition is detected, treatment can be provided within the same facility. These entities typically provide a range of health services for women, including prenatal and maternal services. The new regulations make their functioning impossible, contrary to express congressional intent.

In addition, the record below, like the record considered by the First Circuit in *Commonwealth of Massachusetts*, 899 F.2d 53, shows that most clinics (whether they are free-standing, hospital-based, part of a county health department, or otherwise) lack the resources to locate, furnish, and operate a separate facility in which to provide the services unallowable in a facility receiving Title X funds. Nor can such a facility be sustained with the ongoing costs of duplicative staff, administration, and maintenance costs. As the court stated in *Commonwealth of Massachusetts*, 899 F.2d at 74, "[t]he practical effect of the regulations is to restrict signifi-

to encompass all of the fees and grants coming into those recipients' family planning programs. *See supra* note 59.

65 *Family Planning Grantees, Delegates, and Clinics, 1987/1988 Directory*, Family Life Information Exchange under contract with the U.S. Department of Health and Human Services, Office of Population Affairs.

cantly the ability of the recipient organization to engage in the forbidden counseling, even on its own time with its own money."[66]

Such a situation, of course, stands in sharp contrast to the coordination and integration mandates of the Title X statute. Being able to coordinate would naturally include being able to advise the client of her medical condition, discuss other resources in the community, and make an appropriate referral. Integration would, in addition, include the ability of the Title X recipient organization to operate other health care programs in the same location with the same physicians, records, accounting systems and the like. Because the combination of the referral prohibition and the separation requirements completely undermine Congress' goal of integration and coordination, the regulations must be held in excess of statutory authority.

## CONCLUSION

For all the foregoing reasons the judgment of the Court of Appeals should be reversed.

66 The onerous separation requirements of § 59.9 are unnecessary. Systems for proper allocation of a grantee's or government contractor's costs are well established. In the Title X context, they ensure that a Title X recipient will allocate its various expenditures for family planning services to accounts related to its different sources of revenue (*i.e.*, Title X, Medicaid, Maternal and Child Health, state funding, private fees). *See, e.g.*, OMB Circular A-87, Attachment A, § F-§ J; OMB Circular A-122, Attachment A, § C-§ E; 45 C.F.R. Part 95, Subpart E. These allocation methods entail more than mere bookkeeping entries in financial records. Rather, they are overall systems of financial management and control, carefully drawn and developed. The methods of cost allocation are based on documentation of time spent on different projects, overhead costs, etc. The end result of these analyses are "cost allocation plans" or "indirect cost rates" that ensure that costs are allocated fairly and properly.



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Dated: July 27, 1990

# APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

CIVIL ACTION NO. 88 W 158

PLANNED PARENTHOOD FEDERATION OF AMERICA, et al.,

*Plaintiffs,*

vs.

OTIS BOWEN, M.D.,

*Defendant.*

## DECLARATION

SYLVIA CLARK, declares under penalty of perjury that the following is true and correct:

1. I am the Executive Director of plaintiff Planned Parenthood of the Rocky Mountains ("PPRM"); and I am a nurse practitioner and a certified nurse-midwife. I submit this Declaration to support plaintiffs' motion for a preliminary injunction.

2. PPRM operates 12 clinics that are supported by Title X funds, and also provides reimbursement with Title X funds to one physician, plaintiff Freedman, who provides services at his office to eligible patients from his community. These clinics and that office serve about 13,000 patients each year. About 90% of these patients receive their services on a subsidized basis pursuant to a sliding fee scale. The remainder pay the full cost for their services because their income exceeds the maximum (200% of the federal poverty level) eligible for some subsidy.

3. If the regulations that are at issue in this litigation take effect, PPRM will be forced either to impose government-mandated censorship on its physicians and medical staff in its Title X clinics, and thereby treat those patients in an unethi-

cal and medically dangerous way; or to discontinue its Title X program.

4. The regulations forbid our physicians and the medical staff under their supervision in the Title X-funded clinics from providing information relating to abortion to patients regardless of the medical or professional obligation that may exist in any particular case to do so. This will affect two areas of our practice.

5. The first is pregnancy counseling. Many women, upon learning that they are pregnant, request counseling about their options for managing a problem pregnancy. This counseling may be necessary because of a medical condition that endangers either the woman or the fetus, because the pregnancy is the result of a sexual assault, or because the pregnancy will pose unmanageable burdens for the woman or her family.

6. PPRM's present practice, which is consistent with all commonly accepted standards of medical practice, is to provide women who seek such counseling with neutral and objective information about all of their options, including abortion; and then to provide appropriate referrals depending on the woman's decision after the counseling.

7. My understanding of the present regulations is that they forbid the provision of any information about abortion. They require, instead, that the woman, regardless of her medical condition (unless it is an emergency) or her wishes, be given a referral list of prenatal or social service providers who promote the welfare of mothers and unborn children.

8. These requirements will leave PPRM's patients uninformed about their options, regardless of their medical conditions, their personal wishes, and the consequences that could flow from an uninformed choice. Moreover, PPRM will be forced to provide them with referrals that will often not be consistent with their needs, but will also often affirmatively point them in the wrong direction.



9. Even women who ultimately choose to obtain an abortion and are able to locate a provider will be imperiled. The medical risk of an abortion increases as the pregnancy progresses and, at a certain stage of the pregnancy, abortion ceases to be available. PPRM patients will be delayed because of the lack of information made available to them at the earliest moment. This problem is compounded by the fact that poor women tend to seek pregnancy tests later than other women. Thus, many PPRM patients will be forced to undergo riskier abortions, while others will forfeit that option altogether because they will not be able to locate a provider before it is too late in the pregnancy for an abortion.

10. The second area is family planning counseling. All women who come to PPRM for contraceptive services receive a medical examination, the information necessary to make an informed choice about method of contraception and, should they choose it, counseling about their choice. For many women, for reasons related to such variables as age, other medical conditions, or whether they smoke cigarettes, the most effective method (*i.e.*, the pill) may also pose health dangers that are minimized by an alternative method (*e.g.*, a diaphragm) that is less effective. In comparing the risks, the risk (which is generally low) associated with abortion, which is available as a backup for contraceptive failure, is relevant. Therefore, PPRM provides counseling about this information in appropriate circumstances. PPRM also provides, as mandated by the Food and Drug Administration ("FDA"), counseling and information about the possibility of abortion being advisable for women who become pregnant with an intrauterine device ("IUD") in place.

11. I understand that the regulations forbid any counseling with respect to abortion in these circumstances. This censorship will cause many women to make unguided, inappropriate, and health endangering contraceptive choices due to lack of information.

12. In the communities where PPRM is forced to close its Title X clinics, subsidized reproductive health services will in

some instances no longer be available, and in the remaining communities, be drastically reduced. This means that a large number of the women who receive subsidized services at PPRM's clinics will no longer be able to receive this medical care, or will only be able to receive it by traveling to another community where it may be offered.

13. These women are, by definition, poor. Travel for them is, therefore, difficult or unlikely, and thus the clinic closings will amount to a large-scale cutoff of medical care.

14. Even our patients for whom services at Title X clinics are not subsidized will be injured by the loss of continuity of care and the need to locate satisfactory services elsewhere.

15. The regulations threaten injury to PPRM in another way. They impose a requirement of "program integrity" upon grantees that "encourage, promote, or advocate" abortion as a method of family planning. I understand that this requirement will apply to the dissemination of neutral and objective information about abortion (such as in educational programs) as well as to advocacy activities to protect the right to abortion, but that it will not apply to activities opposed to abortion. Moreover, I understand that the regulation does not establish clear and objective standards for meeting the "program integrity" requirement, nor does it establish a procedure by which grantees will be evaluated on this issue.

16. PPRM's 14 non-subsidized clinics provide neutral and objective information about abortion.

17. Three of those clinics also provide abortions; one provides infertility services; and one provides expanded counseling services.

18. Plaintiff Freedman, who provides services to Title X patients for PPRM at his private office, also provides abortions and counseling about abortion to his private patients in the same office.



19. PPRM's headquarters house a laboratory, education, administrative, and executive offices that support all PPRM programs. It also houses a fund raising department and a public affairs department.

20. PPRM maintains an accounting system that assures that Title X and OFP funds support only the subsidized clinics and the eligible clients served by plaintiff Freedman. PPRM has always maintained "program integrity" to the satisfaction of defendant's predecessors.

21. Now PPRM is apparently to be subjected to an unspecified review on this issue, subject to standards that are not established beforehand; and if PPRM were neither disseminating objective information about abortion, nor engaging in advocacy to protect the right to abortion, then apparently it would not be subject to the "program integrity" requirements at all.

DATED: Denver, Colorado
February 4, 1988

/s/ Sylvia Clark
SYLVIA CLARK

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

CIVIL ACTION NO. 88 W 158

PLANNED PARENTHOOD FEDERATION OF AMERICA, et al.,
*Plaintiffs*,

vs.

OTIS BOWEN, M.D.,
*Defendant*.

## SECOND DECLARATION OF SYLVIA CLARK

SYLVIA CLARK, declares under penalty of perjury that the following is true and correct:

1. I am the Executive Director of plaintiff Planned Parenthood of the Rocky Mountains ("PPRM"). I submit this Second Declaration to support plaintiffs' motion for summary judgment.

2. In Colorado, 78.7% of all abortions are performed at eight abortion clinics located in five communities. Three of these clinics are operated by PPRM. None of the eight clinics, however, can be named on the referral list mandated by section 59.8 because they do not provide prenatal care or social services.

3. These clinics are most likely to be the abortion service of choice for poor women because they are less expensive than private doctors. A first trimester clinic abortion will cost from $200–$350, while private doctors charge anywhere from within the same range to $800. Additionally, clinics accept referrals more quickly and easily.

4. All of these clinics generally provide options counseling to women who contact them to inquire about obtaining an abortion.



5. Other than these clinics, the only sources of reproductive health care for poor women in the communities where PPRM has Title X clinics are local health departments and, in some communities, non-profit community clinics, and private doctors.

6. Generally, private doctors charge full standard fees for their services; and thus they are not truly accessible to poor women.

7. The other clinics provide prenatal services. They do not, generally, provide testing, counseling or referrals to pregnant women.

8. There is a delay of anywhere from one to ten weeks to obtain an appointment with these clinics.

9. I believe that a woman who is pregnant and knows that she wants an abortion will most likely not follow up on a referral to a prenatal care clinic. She will not see the sense in doing so, or she will defer care until well into her pregnancy.

10. I believe that a woman who is uncertain about how she chooses to manage a pregnancy also will probably not follow up on such a referral.

11. Some communities where PPRM has a Title X clinic also have anti-abortion counseling centers. These are small organizations that lure pregnant women in for pregnancy tests and referrals for prenatal care, and which engage in aggressive advocacy to discourage choosing abortion.

12. PPRM may be required to include these centers on its referral lists.

13. Thus, the referral list mandated by section 59.8 cannot include information to help women expeditiously locate an abortion clinic; this information must be withheld from them. Instead, the list will contain information that will, to women who have not resolved to carry a pregnancy to term, seem irrelevant. Even those who try to utilize the list in search of helpful information will be jeopardized. They will face delays in being seen in legitimate prenatal clinics, and

the risk of being aggressively discouraged from choosing an abortion if they are seen in the anti-abortion centers.

DATED: Denver, Colorado
March 9, 1988

/s/ Sylvia Clark
SYLVIA CLARK



IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

CIVIL ACTION NO. 88 W 158

PLANNED PARENTHOOD FEDERATION OF AMERICA, et al.,
*Plaintiffs*,

vs.

OTIS BOWEN, M.D.,
*Defendant*.

## SECOND DECLARATION OF LESLIE DURGIN

LESLIE DURGIN, declares under penalty of perjury that the following is true and correct:

1. I am the Executive Director of plaintiff Boulder Valley Women's Health Center ("BVWHC"). I submit this Second Declaration to support plaintiffs' application for summary judgment.

2. In addition to BVWHC, the county health department and three non-profit community health clinics presently provide subsidized health services to poor women in the Boulder County area. (There is a fourth clinic in the area, but it is one of plaintiff PPRM's Title X clinics.)

3. There are, of course, also private doctors; but they are generally too expensive for poor women.

4. Neither the health department nor the community clinics provide testing, counseling or referral services for women who are, or suspect they may be, pregnant. Instead, they refer women to BVWHC for these services, and we, in turn, refer women to them for prenatal care and services.

5. A woman referred either to the health department or one of the community clinics for a prental appointment will wait about three weeks for that appointment.

6. I believe that a woman who knows that she wants an abortion will not follow up on such a referral because she will not see the relevance of prenatal care to her choice.

7. I also believe that a woman who is uncertain about whether or not to carry a pregnancy to term, or a woman with medical problems which are diagnosed at BVWHC and which are related to the pregnancy, likewise may not follow up on such a referral because she too will not see the relevance of a referral to a prenatal care service.

8. Also located in Boulder County is the Boulder Abortion Clinic which is the practice of Warren Hern, M.D. Hern is a nationally recognized expert in abortion practice, and the author of a standard text in the field, *Abortion Practice* (1984).

9. Hern regularly provides options counseling to women he treats.

10. BVWHC will not be permitted, however, to list Dr. Hern on its referral list because his principal business is abortion.

11. Thus, BVWHC will be forced to provide a referral list that not only provides no appropriate information to women seeking or considering an abortion, but it will actually hide from these women information that is appropriate and medically important to them.

DATED: Boulder, Colorado
March 9, 1988

/s/ Leslie Durgin
LESLIE DURGIN



IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

CIVIL ACTION NO. 88 W 158

PLANNED PARENTHOOD FEDERATION OF AMERICA, et al.,
*Plaintiffs*,

vs.

OTIS BOWEN, M.D.,
*Defendant*.

## DECLARATION

KARRIE GALLOWAY, declares under penalty of perjury that the following is true and correct:

1. I am the Executive Director of plaintiff Planned Parenthood Association of Utah ("PPAU"). I submit this Declaration to support plaintiffs' motion for a preliminary injunction.

2. PPAU receives a grant of approximately $450,000 in Title X funds from the defendant. PPAU uses those funds to operate six family planning clinics in Utah, to reimburse physicians who provide family planning services in their private offices in five communities pursuant to PPAU's rural health program, and to operate an Education Center.

3. PPAU is the only Title X grantee in the State of Utah. The Utah Department of Health is not eligible for Title X funds. See *Jane Does 1-4 v. Utah Department of Health*, 776 F.2d 253 (10th Cir. 1985).

4. Other than PPAU, subsidized reproductive health services are available in Utah in only a few counties, and then only to a limited degree.

5. PPAU's Title X clinics annually treat about 14,000 patients. About 50% of these patients receive free services and another 20% receive subsidized services according to a sliding fee scale that is based on the patient's income. Most of the remainder receive services at the Title X clinics, but pay a fee computed to cover the full costs of the services provided to them.

6. If the regulations at issue here take effect, PPAU will be forced to discontinue its Title X program for two reasons.

7. The first reason relates to the unethical and irresponsible censorship of medically necessary information that I understand the regulations will impose. I understand that the regulations will forbid our Title X clinics from providing any counseling or medical services to pregnant patients and will forbid those clinics from providing any information about abortion to any patient. If the pregnant woman faces a life-threatening emergency, I understand that we will be permitted to make a specific and appropriate referral; and if she has another medical condition of which we learn, we can tell her of it and advise her to seek treatment.

8. For reasons of ethics and liability, PPAU would not agree to comply with these restrictions. As I outline below, they will harm our patients.

9. Many of our patients first learn that they are pregnant at our clinics. Many then seek counseling about their options for managing that pregnancy. They may seek counseling because of medical conditions, such as cancer or diabetes, that threaten the health of either the woman or the fetus, because the pregnancy is unwanted, because it is the result of a sexual assault, or because the pregnancy will pose unmanageable burdens for the woman or her family. In these counseling situations, medical and ethical standards dictate that the woman receive objective information about all options available to her, including abortion.

10. The new regulations will, as I understand them, prevent PPAU's staff from providing any counseling to pregnant women about their options. Instead, we will be permitted only to provide pregnant patients a list of referrals to places that offer prenatal or social services and that promote the welfare of mothers and unborn children. These patients will thus be sent away without any information about their options, regardless of their need or desire for that information. They will, therefore, be forced to make medically and personally significant choices in ignorance.



11. They are unlikely to find this information elsewhere because of the low income level of most of our patients, and the almost total unavailability other than through PPAU of subsidized reproductive health care in Utah. Moreover, the referral list required by the regulations will often direct women to providers who are not equipped to respond either to the medical problems or to the personal concerns of our patients. The referral list will often affirmatively misdirect patients.

12. This ban on pregnancy counseling and appropriate referral endangers women who would eventually choose abortion because they will not obtain, or will be delayed in obtaining, the information and referrals necessary to exercise that choice. Abortion increases in risk as a pregnancy advances, and at some point becomes unavoidable. Therefore, the delay in giving women information will delay their exercising a choice. They will thus be forced either to undergo riskier abortions, or will lose that choice altogether.

13. Many patients consult our clinics for family planning services. We provide physical examinations, counseling and information about the benefits and risks of all available methods of contraception, and contraceptive methods.

14. For many women, because of certain factors such as age or cigarette smoking, the most effective method of contraception (i.e., the pill) may pose significant medical risk. For the purpose of allowing women in such situations to make informed choices, we provide counseling and information about alternative methods such as a barrier method, that

may be less effective but that, with the available backup of abortion, may be significantly safer.

15. For women who choose an intrauterine device ("IUD"), we provide information required by the Food and Drug Administration that, should the woman become pregnant with the IUD in place, an abortion should be considered. We also counsel about this information.

16. The new regulations will, as I understand them, forbid our Title X-funded clinics from providing counseling to our family planning patients about this information with respect to abortion.

17. Without an understanding of this information, they will be at increased medical risk in their contraceptive choices.

18. The new regulations will also force a radical censorship of our Educational Center. The Center is located in our Salt Lake City headquarters, with branches at our clinics. It is a library and resource center for students, parents, and educators, and contains books, files, and other materials on family planning, reproductive health, teenage pregnancy, sexuality education, and birth, growth, and development. It is staffed by educators who make presentations to interested groups.

19. All of the materials in our library are selected because we view them as objective, accurate, and neutral. Many of the materials mention or discuss abortion.

20. A few of the materials focus primarily on abortion.

21. Even though these materials are objective, neutral, and accurate, they are purchased with non-Title X funds.

22. The educators present information that is objective, accurate, and neutral. Often in a presentation, an educator will mention, refer to, or discuss abortion.

23. Occasionally, an educator will make a presentation that focuses on abortion. In these instances, however, even though the presentation remains objective, neutral, and accurate, salary and related expenses are paid by non-Title X funds.



24. As I understand the regulations, PPAU will have to eliminate all information about abortion from its Education Center or find another source of funding for it.

25. PPAU would not be able to fund the Center from existing revenues.

26. Therefore, PPAU would be forced either to eliminate the Education Center, or administer it in a way that presented inaccurate or incomplete information to the public.

27. The second reason relates to the regulations' provisions concerning "program integrity." These indicate that PPAU will undergo a review of its activities and structure to determine whether there is sufficient separation of its Title X activities from its other activities. Yet the regulations neither set forth the process for the review, nor the requirements to be met. Moreover, I understand that these requirements will have be be met because PPAU engages in activities to disseminate neutral and objective information about abortion, and to protect the right to legal abortion; and that these requirements would not be imposed if PPAU engaged in activities opposed to abortion.

DATED: Gearharts, Oregon
February 5, 1988

/s/ Karrie Galloway
KARRIE GALLOWAY

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

CIVIL ACTION NO. 88 W 158

PLANNED PARENTHOOD FEDERATION OF AMERICA, et al.,

*Plaintiffs*,

vs.

OTIS BOWEN, M.D.,

*Defendant*.

## SECOND DECLARATION OF KARRIE GALLOWAY

KARRIE GALLOWAY, declares under penalty of perjury that the following is true and correct:

1. I am Executive Director of plaintiff, Planned Parenthood Association of Utah (PPAU). Prior to taking that position in December, 1987, I was, for four years, director of clinical services for PPAU. In that position, I was responsible for supervision of counseling and referral practices at PPAU clinic sites. As Executive Director, I remain responsible for ultimate supervision of counseling and referral services. Because we have not yet hired a replacement for the clinic director position I vacated, I retain direct responsibility over those services.

2. If the proposed regulations go into effect, our patients will not receive the counseling they need to resolve problem pregnancies and the information they need to obtain abortions.

3. Providers of abortion services accessible to low income women will not appear on the referral list which the regulations require to be provided to our patients. The regulations say that providers whose principal business is the provision of



abortions may not appear on the referral list. Yet, virtually all abortions in the State of Utah are performed at two free standing clinics whose principal business is provision of abortions: The Utah Women's Clinic and the Wasatch Women's Clinic, both in Salt Lake City. Although some abortions are performed at two hospitals, their services would not ordinarily be available to our patients. At one, the University of Utah Medical Center, only second trimester abortions are performed, and these only in life threatening circumstances. At the other, St. Mark's Hospital, a private institution, abortions are available only to patients of physicians on staff and second trimester abortions are performed only in cases of fetal abnormalities or life threatening circumstances. In contrast, Utah Women's Clinic, which would be excluded from the list, offers elective abortions though the twenty-first week of pregnancy (past that point, abortions are offered only for fetal abnormalities or life-threatening circumstances). Abortions at those hospitals are also many times more expensive then those offered at the two free standing clinics.

4. Although some doctors provide abortions to their private patients in their offices, they are generally unwilling to provide abortion services to Planned Parenthood's low income patients.

5. Because providers of accessible abortions will not appear on the referral list, and the new regulations forbid us from discussing abortion with our patients, they will be dependent for information about abortion and counseling upon the prenatal care and social services agencies which are permitted to appear on the list. These providers, however, are not set up to offer the type of expedited counseling and informational services routinely available at Planned Parenthood.

6. Such agencies, which will include state and county health departments and community health centers, are geared toward dealing with women who seek their services for prenatal care: to assist with a wanted pregnancy. Therefore, although questions may be answered on an *ad hoc* basis,

counseling and information regarding options for managing an unwanted or problem pregnancy, including abortion, are not routinely offered to patients. Moreover, no provider of prenatal care that would qualify to appear on the referral list has a distinct options counseling service such as that offered to all patients with positive pregnancy tests at Planned Parenthood. The only other agencies that have such an options counseling service are, in fact, the two abortion providers excluded from the referral list.

7. Whether a patient receives the counseling and information she needs at the referral agency will therefore depend on whether she actively seeks information and counseling and whether the particular staff person she encounters has the time and expertise to competently help her. Because the regulations bar counseling about or "promotion" of abortion, we will not be able to guide patients in how to get that counseling and information, even where it is available.

8. Moreover, it is highly unlikely that our patients will keep appointments for prenatal care when they want abortions or are even undecided about abortion. As previously stated, we will be unable to encourage them to keep the appointments in order to obtain counseling or information about abortion.

9. Even if the information is ultimately obtained, delay is created by having to get it from a secondary source rather than directly from PPAU. In addition, it may take as long as a month to get an appointment with some prenatal care providers.

10. As detailed in other declarations, delays add to health risks, but they also make abortions more expensive. First trimester abortions cost $250 at both the Utah Women's Clinic and the Wasatch Women's Clinic. At Utah Women's Clinic (the only one of the two that performs second trimester procedures) an abortion at 13 to 14 weeks costs $360, at 15 to 16 weeks, $500, at 17 to 18 weeks, $600, at 19 weeks, $700 and at 20-21 weeks, $900. These health and monetary burdens fall



particularly heavily on teenagers who already delay more than adult women in seeking help with problem pregnancies.

DATED: March 9, 1988

/s/ Karrie Galloway
KARRIE GALLOWAY

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

CIVIL ACTION NO. 88 W 158

PLANNED PARENTHOOD FEDERATION OF AMERICA, et al.,
*Plaintiffs*,

vs.

OTIS BOWEN, M.D.,
*Defendant*.

## DECLARATION

DAVID A. GRIMES, M.D., declares under penalty of perjury:

1. I am a physician licensed to practice medicine in California, Georgia and North Carolina.

2. I am Professor of Obstetrics and Gynecology and Professor of Preventive Medicine at the University of Southern California (USC) School of Medicine in Los Angeles, California.

3. I am also engaged in the private practice of medicine, specializing in obstetrics and gynecology. As part of my practice I counsel and treat pregnant women and perform abortions.

4. Prior to accepting the position of Professor at USC, I was with the Department of Health and Human Services' Centers for Disease Control (CDC) in Atlanta for nine years. From 1983 to 1984, I was chief of the Abortion Surveillance Branch of the CDC. In this position, I was the principal health official within the Department of Health and Human Services (DHHS) responsible for monitoring abortions throughout the United States, including their incidence and



the mortality and morbidity (complications) associated with them. While working at the CDC, I personally supervised data collection and evaluation of over 10 million abortions.

5. I have published over 50 articles on abortion and maternal health in medical journals. I am an expert in abortion epidemiology: the study of the safety of abortion and prevention of its complications.

6. I submit this affidavit in support of plaintiffs' motion to enjoin regulations recently promulgated by DHHS to govern federally-funded family planning clinics.

7. The ban on abortion counseling and referral will harm the health of women and violate the professional and ethical duties of physicians.

8. Any delay increases the health risks of abortion. For example, a woman 11 to 12 weeks pregnant who delays an abortion until the 13- to 14-week range doubles her risk of death and serious complications. With increasing gestation, the cost of the procedure also rises, while its availability decreases. It is imperative, therefore, that women desiring abortions obtain the earliest possible access to services.

9. There are numerous instances where women have preexisting medical conditions which pregnancy may worsen. These include diabetes, cardiac disease, collagen vascular diseases, kidney disorders, and certain cancers. It is rare for these conditions to be imminently life-threatening when diagnosed in early pregnancy. Rather, the pregnancy may worsen the condition to the extent of eventually threatening the woman's life or hastening her death. In others, it may mean the woman's health could be permanently adversely affected. One of these situations is diabetic retinopathy, where pregnancy can so worsen the condition as to cause blindness.

10. In such situations, protection of the patient's health requires the physician to advise the woman that abortion is an option she should consider, although the choice between accepting the health risks entailed in continuing the pregnancy or terminating it is ultimately hers. If the woman

decides on abortion, the physician should provide a referral to an abortion provider if he or she does not provide abortions. Moreover, because abortions become more dangerous, expensive and difficult to obtain the later in pregnancy they are performed, it is especially imperative that when a woman has chosen an abortion which is indicated for medical reasons, any referral be prompt and directly to a provider of abortion services rather than an intermediary "social service" or prenatal care agency.

11. Another situation where counseling and referral regarding abortion is medically indicated is when a woman becomes pregnant with an IUD in place which cannot be removed. In such situations, the presence of the IUD may cause a spontaneous septic abortion which can endanger the woman's life. It is therefore recognized medical practice to discuss the possibility of early induced abortion with these patients before the situation becomes a life-threatening emergency.

12. Another situation where physicians would be derelict in their professional and ethical duties to discuss abortion with a patient is where there is the known or suspected possibility of genetic or congenital problems with the fetus. Some of these problems are incompatible with life or survival past infancy. An increasingly widespread example is AIDS. When a woman tests positive for the virus which causes AIDS, her fetus stands up to a 50 percent chance of being infected by the virus during gestation or birth. Most of these infants suffer greatly and die in the first years of life. If a physician is aware that a pregnant patient is infected with the virus, it is his or her medical and ethical obligation to advise the patient of the risk to her fetus and the option of abortion if she wishes to avoid the risk.

13. Other examples of conditions which a family planning clinician may be aware of and for which counseling regarding abortion is professionally obligatory include Tay Sachs disease, a condition which invariably causes death in infancy or early childhood and is most prevalent among Jews of Eastern



European origin. If a provider is aware that a patient has a family history of the disease, he or she is professionally obligated to advise the patient of the availability of tests for the disease and of the options should the outcome show the fetus is afflicted.

14. Another example, Down's Syndrome (mongolism), is a genetic anomaly that usually causes retardation. Since the risk is greatest among women over the age of 35, such women should be advised of the availability of amniocentesis to test for the condition and the options if the fetus is found to have it.

15. Apart from abortion, there are conditions which occur during pregnancy which require referral to specialized providers. For example, a physician finding an early cancer in the breast of a patient should promptly refer her to a surgeon. By allowing referral, when a condition "relates to pregnancy," only to providers of generalized prenatal care, the regulations would delay treatment and thus endanger the lives of such pregnant women and their offspring.

DATED: February 4, 1988

/s/ David A. Grimes, M.D.

DAVID A. GRIMES, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

CIVIL ACTION NO. 88 W 158

PLANNED PARENTHOOD FEDERATION OF AMERICA, et al.,

*Plaintiffs*,

vs.

OTIS BOWEN, M.D.,

*Defendant*.

## DECLARATION

KIRTLY JONES, M.D., declares under penalty of perjury that the following is true and correct:

1. I am the Medical Director of plaintiff Planned Parenthood Association of Utah ("PPAU"). I am also Assistant Professor of Obstetrics and Gynecology at the University of Utah Medical Center in Salt Lake City, Utah.

2. I submit this declaration to support plaintiffs' request for a preliminary injunction staying the regulations that are the subject of this action from taking effect.

3. I am responsible for the medical care and counseling provided to the approximately 14,000 patients treated by PPAU each year. I carry out this responsibility by training staff and reviewing patient charts at all of PPAU's clinics and by seeing, personally, approximately 60 patients each month who have special medical problems.

4. I am familiar with the statements made in the Declaration of Karrie Galloway about the injuries to patients and breaches of duty by PPAU staff that the regulations will impose. I agree with those statements.



5. I want to highlight two particular areas of PPAU's practice where the impact of the censorship imposed by the regulations will be particularly egregious.

6. The first area involves counseling PPAU provides to pregnant women. Many women contact us for advice about the effect of drugs or infectious viruses upon a pregnancy they would like to carry to term. Common among these drugs are accutane, which is commonly prescribed for acne but will cause congenital heart defects in a fetus, as will lithium, which is commonly prescribed for manic-depressive behavior. Many street drugs, including cocaine and heroin, have profound effects on a fetus which might affect a woman's decision to take a pregnancy to term. Infectious viruses such as rubella or the AIDS virus are transferred across the placenta to cause congenital rubella or AIDS in the newborn infant, and this also affects a woman's decision about whether to carry to term.

7. I see some of these women personally, and PPAU's staff regularly consults me before advising the others.

8. We have a duty, I believe, not only to counsel these women about the drugs and their effects on the fetus, but also to discuss their options for managing the pregnancy when the drugs have likely caused a problem.

9. Among these options is abortion.

10. We carefully provide only objective, non-directive information.

11. Failure to do so will cause serious harm to some of these patients, will inevitably result in women unwittingly assuming high risk pregnancies, children born with congenital malformations, and I believe would be a breach of my and PPAU's duties to our patients.

12. The second area involves contraceptive counseling. Many women who come to PPAU have an initial preference for the birth control pill. For reasons relating to age or medical condition, such as diabetes or hypertension, the medical

risks associated with the pill are too high. For many of these same women, an intrauterine device ("IUD") is not a possible option.

13. I directly counsel many of these patients.

14. I believe that I am obligated to counsel these patients about the advisability of choosing a barrier method.

15. I believe that I am also obligated to discuss with them the risks of failure associated with a barrier method, the significant health risks to them of pregnancy and childbirth, and the availability and relatively low health risks of abortion as a backup.

16. As I understand the regulations, I would no longer be able to counsel these patients with respect to abortion.

17. Failure to do so would place the health of some of these women in significant peril and would, I believe, breach my duty to them.

DATED: Salt Lake City, Utah
February 4, 1988

/s/ Kirtly Jones, M.D.
KIRTLY JONES, M.D.



IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

CIVIL ACTION NO. 88 W 158

PLANNED PARENTHOOD FEDERATION OF AMERICA, et al.,
*Plaintiffs*,

vs.

OTIS BOWEN, M.D.,
*Defendant*.

## DECLARATION

THOMAS M. VERNON, declares under penalty of perjury that the following is true and correct:

1. I am the Executive Director of the Colorado Department of Health ("Department"). I submit this Declaration to support plaintiffs' motion for a preliminary injunction.

2. The Department is the grantee of Title X funds in the State of Colorado. The Department receives about $1.2 million annually pursuant to the Title X program.

3. We distribute these funds to 23 providers of health services. These providers include two of the plaintiffs here, Planned Parenthood of the Rocky Mountains ("PPRM") and Boulder Valley Women's Health Center ("Boulder Valley"). The other providers are two hospitals, one other not for profit agency, and 18 local health departments or local county health providers.

4. We also distribute about $1 million in state funds to these providers.

5. Through this system, subsidized reproductive health care is provided to over 40,000 patients. Approximately 85% of these patients have incomes at or below 150% of the feder-

ally defined poverty level, and approximately 33% of these patients are under the age of 20. Thus this system largely provides services to people who are not likely to find care elsewhere.

6. Among the services provided are pregnancy tests and counseling to almost 7,000 patients. Under existing Title X guidelines and accepted standards of medical care, the counseling is voluntary, nondirective, and covers all options legally available for managing a pregnancy. These are carrying to term and keeping the child, adoption, and abortion. Women who choose abortion are given the names of facilities where abortions are performed.

7. The regulations will eliminate the provision of this crucial information to these women who are Colorado's poorest and least likely to find it elsewhere.

8. The result will be more unwanted children.

9. Moreover, I believe restricting physicians' and other medical professionals' ability to provide needed information to their patients is ethically and professionally unacceptable.

10. These same problems will arise in the family planning counseling provided by our grantees.

11. Sometimes it is medically appropriate to discuss abortion when counseling about methods of contraception. This would occur, for example, when counseling a woman for whom an intrauterine device ("IUD") is the method of choice. The Food and Drug Administration requires that she be informed that should she become pregnant with the IUD in place, she should consider obtaining an abortion.

12. I understand that the regulations will stifle the ability of our grantees to meet this duty.

13. As a result, many women will choose a contraceptive method without having received complete information, thereby incurring unnecessary and significant health risks.

14. I understand that PPRM and Boulder Valley will probably discontinue their Title X programs rather than comply



with these restrictions on their abilities to communicate honestly and objectively with their patients. I expect that many, if not all, of the Department's other Title X grantees will do likewise.

15. This will have a catastrophic effect on health care for poor women in Colorado both because of the loss of these services from established providers with whom they are familiar, but also because of the uncertainty of whether the Department will be able to locate competent providers willing to practice medicine under the unethical restraints imposed by the regulations.

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/s/ Thomas M. Vernon, M.D.
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